

U.S. NAVY MEDICINE

November 1978



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CORRESPONDENCE: All correspondence should be addressed to: Editor, *U.S. Navy Medicine*, Department of the Navy, Bureau of Medicine and Surgery (Code 0010), Washington, D.C. 20372. Telephone: (Area Code 202) 254-4253, 254-4316, 254-4214; Autovon 294-4253, 294-4316, 294-4214. Contributions from the field are welcome and will be published as space permits, subject to editing and possible abridgment.

The issuance of this publication is approved in accordance with Department of the Navy Publications and Printing Regulations (NAVEXOS P-35).

NAVMED P-5088

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COVER: Behind this 290-pound rig is LCDR Pamela A. Kaires (MC), the Navy's first woman to dive to depths of 300 feet—and the first ever to qualify as a submarine medical officer (see page 3). Photo by PH2 Jim Preston.

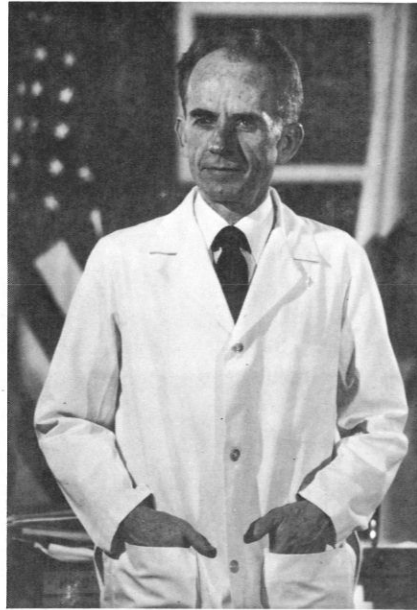
From the Surgeon General

The Unsung Specialists

Various specialists on our Medical Department team are highly lauded from time to time. Generally, attention is drawn to individuals operating in a primarily clinical mode. But when the overall Navy mission is examined, we must recognize that we have unsung specialists among us: those engaged in operational medicine.

The readiness and proper functioning of the forces afloat is the "name of the game." But the operational medicine specialist stands in the front line. He or she is unique and has no precise parallel in the civilian community. Needless to say, the flight surgeons and undersea physicians are in the vanguard—but so, too, are the aviation and diving physiologists, and the aerospace and submarine medical technicians, both officer and enlisted, who back up those physicians, and without whom those physicians could not function.

I salute all of you and wish to make known to you publicly that we



recognize and appreciate your talents and dedication.

I am taking a personal interest in programs designed to augment the attractiveness of your career patterns and your professional progress. I feel strongly that you are an integral part of the medical team.

Those of us who are not primarily in operational medicine might well consider not only the contribution to be made, but the rewards to be harvested, by joining your ranks.

And we should see to it that operational medicine is no longer the repository of the unsung.

W.P. ARENTZEN
Vice Admiral, Medical Corps
United States Navy

New Hospital Corps Division Director Named

CAPT Roy W. Tandy (MSC) has been named director of the Navy Medical Department's Hospital Corps Division. He reported on board at BUMED in late July, after last serving as director of administrative services at NRMC Great Lakes.

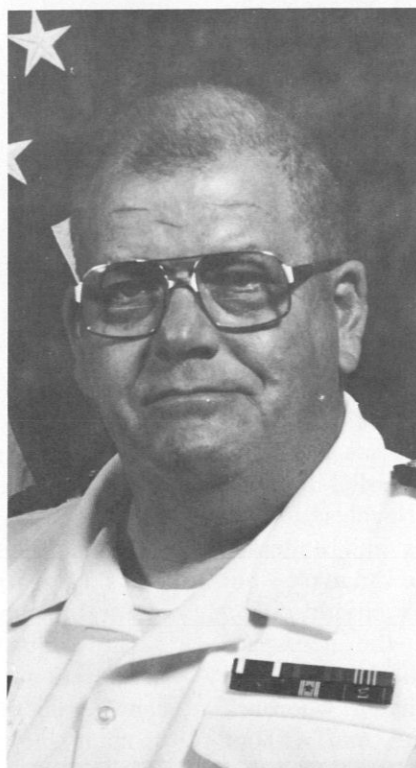
CAPT Tandy entered the Navy as a seaman recruit in 1951 and was commissioned an ensign in 1957. His naval service includes assignments aboard the USS *Staten Island*, an icebreaker in the Arctic; as an independent duty corpsman aboard the minesweeper USS *Fortify*; as a data-processing officer at Bethesda and San Diego; and as administrative/supply officer in Okinawa with the Marines during the Vietnam conflict. More recently, he established the naval medical region in Hawaii and served as its first executive officer before his appointment as DAS at Great Lakes.

"The Hospital Corps is relatively healthy and becoming more so each day," says CAPT Tandy. "There are, right now, 23,271 Hospital Corps billets around the world, filled by 22,026 corpsmen. If we can fill the school seats that we have, we should reach 100% in the next fiscal year."

The Hospital Corps has taken a number of new initiatives with respect to training, including development of a respiratory care technician package that will provide seats for selected corpsmen in the Army School at Fort Sam Houston, beginning next year.

Another area under study is management training for the E-8 and E-9 communities. "There has been no formal training in management for these people, nor have

there been openings in middle-management positions," CAPT Tandy says. "One of the initiatives of the Surgeon General is to bring the E-8 and E-9 into middle-management positions at our medical facilities."



In the Hospital Corps, as elsewhere in the Navy, much planning is being devoted to making full use of the talents of women—and to preparing for their service aboard Navy ships and in other "new" assignments.

"Young women in the Hospital Corps are beginning to enter fields that have been traditionally male,

such as medical repair," says CAPT Tandy. "I'm very pleased with that and want to encourage it. We're increasing the basic ratio of females to males."

As to problems for the Hospital Corps, the biggest one just now, he says, is "getting students into the schools. If we don't have enough qualified volunteers, we can't bring our technical specialties up to strength. In the most recent selections, we were able to fill most of the school seats with reasonably well-qualified people, but pharmacy and submarine medicine are desperately short of volunteers." (A recent increase in bonus pay for submariners should help that category, he notes.)

The retention rate for hospital corpsmen at the first-term decision point is currently 22.1%—much better than that of the recent past—but there's room for further improvement, says CAPT Tandy. "We need to offer these people career patterns that meet their needs. We recognize the need, and we're working on it."

Of his new job, he says: "I'm pleased and to some extent flattered to be here. I'm also somewhat amazed by my misconceptions of the Bureau—and I suspect the misconceptions of many field officers—as to its omnipotence. We are not a Navy unto ourselves, but part of the U.S. Navy, and I'm convinced that awareness may be more acute here than in the field."

"There seems to be a tendency in the field to think that BUMED is all-powerful. But we vie for the same assets as the rest of the Navy. There's no cornucopia of dollars and people here at the Bureau."

Dr. Kaires Gets Her Dolphins

At the Naval Undersea Medical Institute, Groton, Conn., LCDR Pamela A. Kaires (MC) recently became the first woman ever to receive the twin dolphin pin that signifies qualification as a submarine medical officer.

The award ceremony, held in late September, marked LCDR Kaires' successful completion of a rigorous six-month course in submarine medicine, covering biomedical disciplines as applied to the submarine and diving environment.

The course included eight weeks of instruction at the Navy School of Diving and Salvage, in Washington, D.C., during which Dr. Kaires became the Navy's first woman to dive to depths of 300 feet, using the 290-pound Mark V mixed-gas diving outfit.

Dr. Kaires, a graduate of The George Washington University Medical School in the nation's capital, completed her internship and her residency in internal medicine at NRMC San Diego. She came by

her interest in Navy medicine naturally, since her father—RADM Anthony K. Kaires—is a retired Navy dentist and her sister—LT Cynthia Kaires—is a Navy nurse.

Next month, Dr. Kaires will leave New London for a new assignment at the Naval Regional Medical Clinic, Hawaii, with additional duty to Submarine Squadron Seven at Pearl Harbor. Though current law prohibits her from actually serving aboard a submarine, she sees many possibilities ahead for challenging work in her chosen specialty, and looks forward particularly to involvement in hyperbaric research.

For Dr. Kaires, diving school was one step along the rigorous way to her dolphins.

Photo by PH2 Jim Preston



Notes & Announcements

In memoriam . . . RADM Alfred W. Chandler, DC, USN (Ret.), former assistant chief of the Bureau of Medicine and Surgery for Dentistry and chief of the Dental Division, died 24 Sept 1978, at age 88.

RADM Chandler was born in Newport, R.I., and graduated from the University of Pennsylvania Dental School in 1915. He enlisted in the Navy in 1917, one week after the United States declared war on Germany, and subsequently served as senior dental officer at U.S. naval bases and overseas, as well as at the U.S. Naval Academy, Annapolis, Md.; Naval Training Center, San Diego, Calif.; and U.S. Naval Hospital, St. Thomas, Virgin Islands.

RADM Chandler was a member of the first dental officer class at Washington's Naval Dental School. In 1923, after completing postgraduate work at Northwestern University, he became head of the prosthetic and operative departments at the Naval Dental School. In 1947, RADM Chandler, a specialist in prosthodontics, became assistant chief of the Bureau of Medicine and Surgery for Dentistry and chief of the Dental Division. He was responsible for establishing the first Navy schools for dental technicians at Bethesda, Md., Great Lakes, Ill., and San Diego, Calif. He also was responsible for establishing dental facilities in all ships and stations having dental personnel. He became the dental inspector general in 1948 and held this position until he retired in 1952.

RADM Chandler was a member of the Capitol Clinic Club, American Denture Society, and American Dental Association; a diplomate of the American Board of Prosthodontics; and a fellow of the American College of Dentists. He held the Legion of Merit and the Hayden-Harris Award for his contributions to the history of dentistry.

Dental continuing education courses . . . The following dental continuing education courses will be offered in February 1979:

National Naval Dental Center, Bethesda, Md.

Periodontics	5-7 Feb 1979
Fixed Partial Dentures	26-28 Feb 1979

Eleventh Naval District, San Diego, Calif.

Complete Dentures	20-22 Feb 1979
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U.S. Army Institute of Dental Research, Walter Reed Army Medical Center, Washington, D.C.

Advanced Clinical Oral Pathology	5-8 Feb 1979
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Requests for courses administered by the Comman-

dant, Eleventh Naval District, should be submitted to: Commandant, Eleventh Naval District (Code 37), San Diego, Calif. 92132. Applications for other dental continuing education courses should be submitted to: Commanding Officer, Naval Health Sciences Education and Training Command (Code 5), National Naval Medical Center, Bethesda, Md. 20014. Applications should arrive six weeks before the course begins.

Continuing education for Navy nurses . . . The Naval Health Sciences Education and Training Command will sponsor the following continuing education course for Navy nurses:

Anesthesia Update (30 contact hours)
Pensacola, Fla.

5-7 Feb 1979

Designed for Navy nurse anesthetists to present new concepts in methods and techniques in the field of anesthesia.

The course is open to Nurse Corps officers not currently assigned to an overseas billet. However, nurses assigned to Argentia, Newfoundland; Bermuda; Guantanamo Bay, Cuba; Keflavik, Iceland; and Roosevelt Roads, Puerto Rico, who have served at least six months on active duty, may apply. The course is also open on a space-available basis to Nurse Corps officers of the inactive Reserve.

Nurse Corps officers wishing to attend the course should apply to the Naval Health Sciences Education and Training Command (Code 7), National Naval Medical Center, Bethesda, Md. 20014, following procedures set forth in the BUMED Instruction 4651.1 series. Applications should be submitted four to six weeks before a course begins.

AFIP courses offered . . . The Armed Forces Institute of Pathology will offer the following courses:

Genitourinary Pathology 29 Jan-2 Feb 1979

This course consists of a basic and comprehensive survey of the pathology of surgical diseases of the kidney, ureter, bladder, prostate, testis, penis, and urethra. The course is designed for urologists and will be presented by lectures, demonstrations, and the study of microscope slides.

Applicants should be members of the Medical Corps of the Armed Forces or other federal services who are board eligible or certified urologists. Applications from qualified civilians will be considered on a space-available basis.

Seminar and Workshop—Histopathology Techniques 5-9 Feb 1979

The wet workshops will consist of bone techniques, eye techniques, brain techniques, and special staining techniques. These workshops will be held during the first two and half days. Selective training will be offered on Wednesday afternoon to include cryostat, kidney biopsy, spirochete staining, lymph node procedures, preparation and application of the H & E stain, knife sharpening, and the use of plastic (diatex) for tissue section transfer. The remaining day and a half will consist of lecture sessions.

Applicants should be members of the Armed Forces or other federal services. Individuals must have at least one year's experience in a histology laboratory, and the training request must be made by the sponsoring pathologist. Use of a special application form is essential. This form can be obtained by writing The Armed Forces Institute of Pathology, Washington, D.C. 20306, ATTN: AFIP/EDZ. Civilian applications will be considered on a space-available basis.

Pathology of Genetic Disease 12-16 Feb 1979

The genetic aspects of various diseases due to point mutations and chromosomal aberrations will be discussed, using AFIP-accessioned case material to illustrate the pathologist's role in diagnosis. The pathologic effects of many of these diseases in specific organ systems will be reviewed. Lectures will cover the correlation of the clinical and laboratory features with the morphologic alterations of typical examples of diseases due to trisomy aberrations, sex chromosomal anomalies, genetic abnormalities in sexual differentiation, autosomal and x-linked dominant and recessive point mutations. Specific genetic pathologic case problems accessioned at AFIP will be presented to participants and their resolutions discussed.

Applicants should be members of the Medical Corps of the Armed Forces or other federal services who are board eligible, or certified in pathology or other specialties, with an interest in genetic diseases. Other military professional personnel and qualified civilians may apply on a space-available basis.

Further information may be obtained by writing to the Director, Armed Forces Institute of Pathology, ATTN: AFIP/EDZ, Washington, D.C. 20306.

Cold weather medicine and NBC warfare training . . .

Two new training programs developed by the Naval Health Sciences Education and Training Command are now available to Medical Department personnel.

- *Cold Weather Medicine* provides the necessary knowledge to operate effectively in areas of severe cold. The program is a self-study or classroom course consisting of instructional materials, objectives, lecture outlines, a glossary, an annotated bibliography, and an

information source list. The format and contents are designed to help users choose portions relating to their professional and operational needs.

- *Medical Considerations of Nuclear, Biological, and Chemical Warfare* provides information on handling, treating, and protecting personnel from the effects of NBC weapons. This program is a classroom course and consists of tasks, objectives, lecture outlines, a bibliography, and a general information section.

Requests for these programs should be forwarded to: Commanding Officer, Naval Health Sciences Education and Training Command (Code 21), National Naval Medical Center, Bethesda, Md. 20014.

Infectious disease course . . . The second annual University of California, San Francisco course on Infectious Diseases in Clinical Practice will be held 27 Jan-3 Feb 1979 in Sun Valley, Idaho. The course will emphasize clinical management and prevention of viral, bacterial, and mycotic infections, with emphasis on recent advances in diagnosis and treatment. The course should be of interest to general and family practitioners, obstetricians-gynecologists, internists, pediatricians, and general surgeons. There will be lectures and specialty seminars. A comprehensive syllabus will be distributed to participants.

For further information write to: Extended Programs in Medical Education, University of California, San Francisco, Room 569-U, Third and Parnassus Ave., San Francisco, Calif. 94143. Telephone (415) 666-4251.

Clinical cytopathology postgraduate course . . . The 20th Postgraduate Institute for Pathologists in Clinical Cytopathology will be given 23 April-4 May 1979 at The Johns Hopkins University School of Medicine and The Johns Hopkins Hospital, Baltimore, Md. The two-week program is designed for board-certified or -qualified pathologists and will provide an intensive refresher course in all aspects of clinical cytopathology, with time devoted to new techniques and special problems. Topics will be covered in lectures and informal conferences, and discussed over the microscope. A set of slides with text will be sent on loan to each participant for home-study during March and April before the Institute. Credit hours will be 120 in AMA Category 1.

Applications should be received before 28 Feb 1977. For more details write to: John K. Frost, M.D., 610 Pathology Building, The Johns Hopkins Hospital, Baltimore, Md. 21205.

The Surgeon General's 10th Annual Specialties Advisory Conference and Committees' Meeting

This conference was held 12-15 September 1978 in Arlington, Va. Following is a report of the first plenary session of this annual conference. A concluding report will appear in the December issue of U.S. Navy Medicine.

This report represents an edited (sometimes paraphrased or abbreviated) version of the remarks and presentations of specified individuals. Their comments do not necessarily reflect official views of the Navy Department or of the naval service at large.—Ed.

Surgeon General's Keynote Address

VADM W.P. Arentzen, MC, USN
Surgeon General of the Navy

At SAC IX, I devoted my remarks to a general statement of our major problem areas and some of the initiatives we had taken to combat them. I stated my confidence in our ability to confound our critics. I remain confident today.

I will speak of some problems this morning, but first I want to share with you my perceptions of some of the forces impacting on us as a Medical Department.

Shortly after leaving the Office of the Secretary of Defense, James R. Schlesinger observed that, for Americans, security has been too widely viewed as a "given." Too little is it appreciated that the stability we still enjoy is a reflection and legacy of past American involvement and active leadership. He went on to describe the more immediate invisible factors, such as the altered psychological stance of the United States, which is apparently withdrawing from the burdens of world

leadership, with a resultant change in our national defense policy.

This change in national defense policy has placed us in an era of competition for resources unmatched in our experience or in that of our predecessors. The size of our defense budget, although increasing in terms of total billions of dollars, has decreased in terms of real purchasing power, under the pressure of inflation. At this time, relative to the gross national product, our expenditure for defense is somewhat less than 6%.

The Navy and its sister services are undergoing exactly the same pressures. We are being asked to do more and more with less and less. This decrease in dollars with which to buy and run the ships we know we need has had some profound effects. As short a time ago as 1968, the Navy had 976 ships in commission. As of two months ago, we had 485 ships in our active fleet. Building costs are staggering. A carrier costs over \$1 billion. A fighter plane costs around \$20 million. A strike cruiser will cost between \$700 million and \$900 million.

The health care environment, military and civilian, is undergoing similarly inflationary times. In the past year, the total health care bill for the nation was well over \$100 billion. This approaches 10% of the gross national product. The government's share of this bill is approximately \$50 billion. Inflationary pressures, as well as expansion of social programs, could double or even triple those already huge figures within the next 10 or 20 years.

As a result, nationally we see a continuing trend toward federal management of the nation's health care industry, as evidenced by increased structuring of the organization of health services delivery.

Public Law 93-641 gave impetus to this structuring by establishing local, state, and regional entities within which federal and state funds would be dispensed

and managed. Similarly, public law has provided direction for the limitation of federal participation in capital expenditures, as well as a mechanism for monitoring the quality of care under the aegis of professional standards review organizations. The passage of Public Law 94-44, with its emphasis on the delivery of primary care, provides the government for the first time with an obligated, controllable pool of professional health care providers. Implementation of the Occupational and Safety Health Act has provided teeth to federal efforts to control the safety of the work environment, but has at the same time created an expanded requirement for professionals and money to support this effort.

For the Navy, the cost of health care this year will exceed \$1 billion. One out of every six commissioned officers in the Navy is in the Medical Department. Is it any wonder that we are being analyzed, scrutinized, and directed to make every dollar count?

In view of these changes in our environment, what have we done? Well, for too long we have kept our heads in the sand. Instead of coming to terms with any of the real issues confronting military medicine, we spent much of our time waging symbolic power struggles which prevented anyone from making decisions about anything.

In 1973, the draft ended, and the era of the all-volunteer force began. Since 1954 and the beginning of the Berry Plan days, we had welcomed up to a thousand superbly well-trained physicians every year. We used them and let them go their way. After all, another thousand would come next year.

What a waste! Almost one third of the Navy Medical Corps turned over each year, and no one recognized the waste for what it was.

We did this same thing with our other communities: dentists, Medical Service Corps officers, nurses, and corpsmen. With the draft, our supply was limitless. What need was there to conserve manpower, develop stability, train to requirements, or retrench and develop the initiatives needed for a truly responsive and responsible health care system?

Then it stopped. The draft was over. In a flurry of self-righteous excitement, we developed a spate of new programs designed to solve our problems. Each service had its own, but we still hadn't sensed our environment. We still had not learned our lesson: that training was expensive, and that we could no longer afford the luxury of going it alone—in short, that we were in a different era. Manpower was now expensive, approaching 76% of our DOD budget. These programs failed the scrutiny of the analysts and are gone.

Personnel is only one of our problems. Can we continue to justify two hospitals in the same city, doing the same thing? Can we justify two separate medical systems on the same island?

Social economists—the analysts within and without—have recognized us for what we are: a potential testing ground for their systems and theories of health care, in which will be the shape of our national health care systems in the future. We are perfect for their use. We have a good health care delivery system in the military. We are a significant national asset. We offer a ready, prepared, responsive, sustainable force to be mobilized in time of natural crisis or conflict. If we didn't exist, we would have to be invented. We serve as a model, as the nation moves ever closer to the enactment of national health insurance.

Because we are a federal agency, we must and should be responsive to the government's command. But just because of that, we must be especially careful not to become embroiled in pointless philosophic controversy or allow ourselves to be used as a test tube for every new notion. If we are to be the tail that wags the dog of the civilian medical sector, let us wag it with very careful deliberation.

President Carter has stated his intention to introduce legislation establishing a national health insurance program of some sort during this Congress. Foresight and effective planning will help us avoid the paralysis and confusion that are certain to be associated with such a major change in American medicine.

Our mission is unique. We must protect that uniqueness. Most of modern medicine is the same wherever we go, but there are some things in the military that are different, and they must be preserved. Perhaps we have placed too much emphasis on how similar military medicine is to civilian medicine.

To a degree, we have been the authors of our own problems. Our patients have been educated by us to expect miracles in every situation. Our patients have forgotten how to be sick—antibiotics for every fever; mood elevators for every slight depression or fear of one; sleeping pills whenever sleep is delayed for a few minutes; organ transplants as one's own organs wear out. How can we blame our patients? And when escalating demands cannot be met, a bit more bloom comes off the rose.

Competition for available resources will become ever keener, the conflicting imperatives ever more pressing. Success in some eyes will be measured more and more by compromise. We must be ever watchful in that regard.

What does tomorrow hold? What will be the environment in which we will be working?

I think that certain trends now visible will continue. Present indications are that the Department of Defense's role in policy development and resource management will expand. Under the aegis of the Department of Defense, health care regionalization will become more firmly established as a mechanism within

which the military health care system will work. I expect that there will be increasing pressure for, and movement toward, integration of the entire military health care system with the civilian sector.

There is little question that zero-based and capitation budgeting will serve as the basis for future funding. Much of this effort will probably stem from an enrollment system for all classes of our beneficiaries. The general delivery of health care will change. More of our efforts will be directed toward ambulatory health care.

The Surgeons General are meeting regularly to identify our commonalities, share our resources, develop constructive supporting programs, and eliminate duplication. Equipment purchases are being coordinated. Programs are being directed toward the rightful dominant claimant, and joint training efforts are being initiated. We are placing increased emphasis on involving our facility managers in the decision-making process and providing them with the needed information and systemwide awareness required. Increased emphasis is being, and must be, placed on evaluation systems and indicators to tell us at each level how we are doing. We must emphasize cost containment and cost effectiveness, as well as quality of care, if we are to compete effectively. We must increase our ability to translate health care demands into programs and allocation of doctors, dollars, and personnel.

What does all this mean for physician managers in our system? It will require innovative thinking. It will require inventive management. As health care generally comes under relentlessly greater government control and review, the opportunity to work and to exert an influence on the frontier should be an exciting area for imaginative, creative professional growth.

But as much as we need physician managers, we need leaders more. Systems can be managed. People must be led. It is in this latter area that I am uneasy.

During the past 12 months I have visited a large number of our facilities, from Japan to China Lake. I have been disturbed by some of the things I have seen, pleased by even more. But too many times I see evidence of resignation and malaise—what William Raspberry has called “big-picture paralysis.”

It is too easy to say that the problem is so immense, the difficulties are so huge, that one's own efforts don't matter. If we paint the picture big enough, we can paint ourselves right out of any part of the solution. The physician shortage, budget cuts, deteriorating facilities, and the crush of patients to be cared for are all big problems. But even so, individual decisions can have important results for individuals, even if they don't register statistically. Every corpsman who reenlists as a result of your effort is important. Every patient who is satisfied with his clinic experience as a result of your compassion is important. Every physician who extends

as a result of your example is important. They are all important.

The point is not to relieve the Bureau or the Navy of the big-picture responsibilities. The point is that individual effort matters also.

Another attitude which concerns me greatly is less-than-universal understanding and support of our mission. Support of the operating forces is the reason we exist, and service of these forces should be our highest calling. I have spoken with our scholarship students and find general understanding of the operational commitments of the Navy Medical Department—even enthusiasm. This is reinforced by the six-week OCS course at Newport. But much of that is dissipated during the GME-1 year, partly as a result of natural situational inertia; partly because there are few visible role models; and, most disturbing of all, partly because of overt discouragement on the part of staff physicians at our teaching hospitals—including program chairmen.

It is inconceivable to me that such action on the part of career physicians—that such failure to understand why we are here—can take place. That attitude must be turned around.

One of my major goals as Surgeon General has been the removal of barriers between hospital-based and force-based personnel. It is clear that we have not come as far along that road as I would like. I need your individual efforts in this endeavor.

I am concerned about our teachers. Even though numbers of physicians will not be a problem by 1981 or 1982, the availability of good teachers, particularly in the subspecialties, will be a problem. We must retain them. We must retain every one of you in this room. Without you as role models, we won't keep those we need.

Identify potential teachers early. Encourage their participation in your training programs. Solicit their ideas. While the generalist is of great value to the Navy, we cannot afford to become a corps of nothing but generalists.

Some individual efforts are beginning to pay off. Extension of medical officers is better this year than last, for the same time frame. During last year's SAC, we were predicting a physician shortfall between 250 and 400. On 10 October 1978, that shortfall will be 169. That is a shortfall of 4.5%, considerably better than those of our sister services. Even that number is too large, but it is better than we had feared.

We have received additional funds for conference travel—not enough, but more than before. Funds for equipment purchases continue at significantly higher levels. Our scholarship program is fully subscribed. Extension of the existing special pay legislation has been approved, and a new bill to improve and stabilize the special pay provisions has been introduced.

Some intangibles are beginning to emerge. The quality of volunteers seems definitely higher than in the recent past. The level of interest in military medicine appears to be higher. The Uniformed Services University of the Health Sciences is a going concern, and we do have allies now. And these allies are beginning to be heard, in the Congress, in the Department of Defense, and in the Navy.

I am convinced that facing the facts is always healthy and the way of wisdom. I pledge to you my intent to continue to do battle and to yield ground most grudgingly.

Training is our life's blood, and I pledge my full support to that effort. I remain confident; I remain proud.

Someone once said, "You are as young as your faith, as old as your doubt; as young as your confidence, as old as your fear; as young as your hope, as old as your despair. When your heart is covered with the snows of pessimism and the ice of cynicism, then and only then are you grown old."

I am feeling younger every day.



CAPT Bryant

OP-093: A Status Report

CAPT E.M. Bryant, MSC, USN
Office of the Surgeon General

During these past 10 years of SAC meetings, we've seen and experienced numerous changes in our Navy Medical Department, many of which were driven by external forces. As a matter of fact, in the areas of resource and organizational change, the number of externally driven "improvements" has made us wonder whether or not one more improvement might lead to total collapse.

Today my purpose is to report to you another change, this time organizational. However, we are excited by this change, because it makes the Surgeon General an official member of the top-line management team: OPNAV (Echelon 1). It gives him resource sponsorship for all medical and medical training program elements, and it assigns him functional task sponsorship for medical, Navy-wide.

Briefly, that identifies OP-093. Actually, OP-093 is the Office of the Surgeon General in the Pentagon. The Surgeon General becomes director of a major support office (DMSO) in the Chief of Naval Operations organization.

One may ask, Why an OP-093 after all these years? How is it structured? And what is its status today?

In September 1977, the Vice Chief of Naval Operations expressed concern about several aspects of the Navy health care services system. Among these concerns were the medical organizational relationships with Navy; the fact that execution of health services was being directed by the Surgeon General with assistance from the staff of BUMED, a second echelon command; and the fact that the responsibility for health care services at the first echelon level—that is, OPNAV—was fragmented.

As a result, the VCNO tasked RADM Synhorst (Ret.), OP-09E, as the study director to review the organization for health services. The study was completed 1 Jan 1978, and the major findings supported the concerns of the Vice Chief. There were 16 medical billets scattered throughout 13 OP codes, with no central coordination.

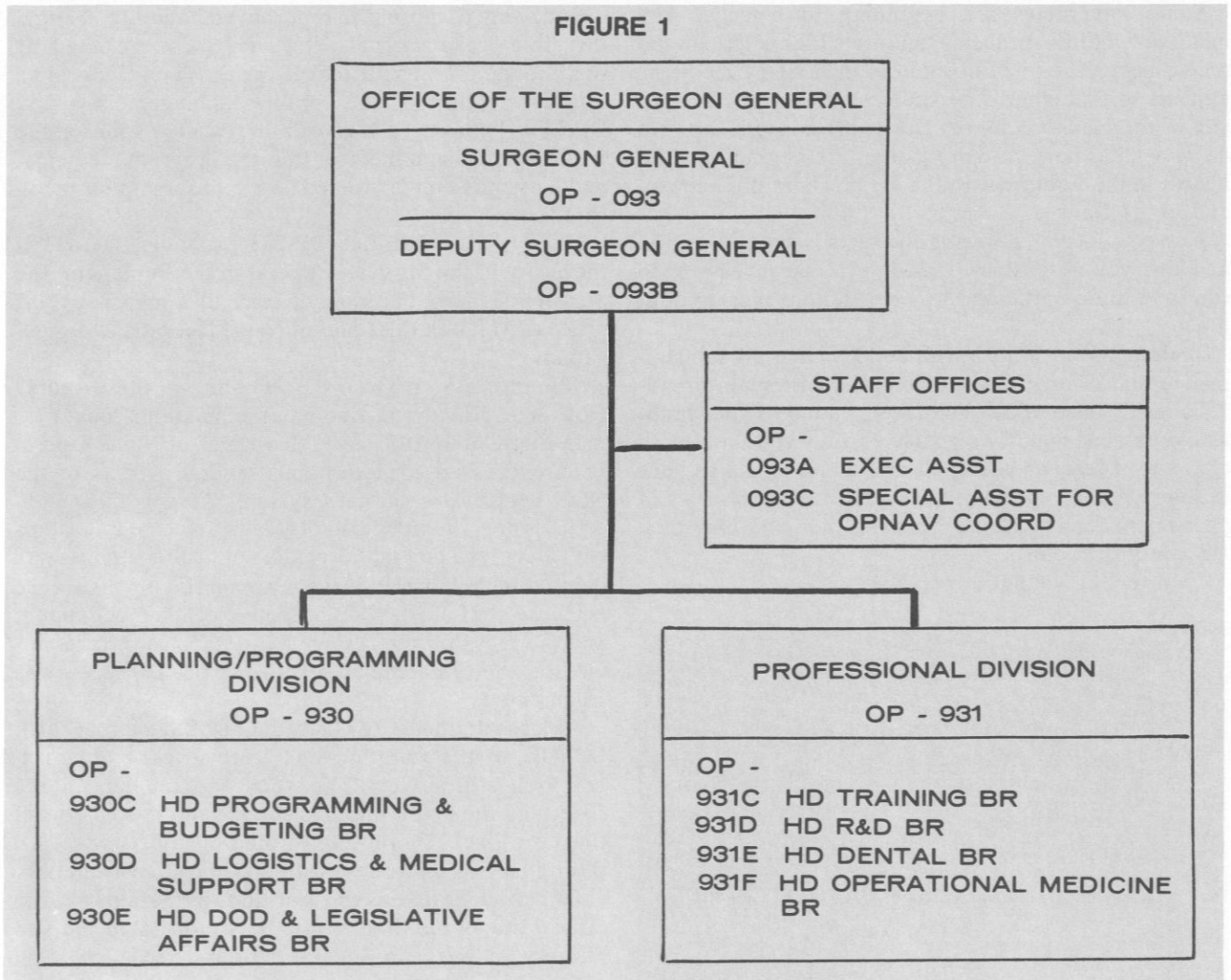
Of particular note is the fact that, by public law, the official title of the Chief of the Bureau of Medicine and Surgery is "Surgeon General." He is a second echelon commander. This placement of the Navy Surgeon General differs from that of the Army and Air Force Surgeons General. They are assigned to the Chiefs of Staff and function on the department headquarters staff.

Generally, the service Surgeons General are perceived by higher authority to be the senior medical professionals on the headquarters staff, whether this placement exists or not. Over the years, medical functions in the Navy which should have been performed by the CNO staff were accomplished by BUMED. Frequently, recommendations on policy matters were made by BUMED without CNO awareness. More frequently, authorities above the CNO communicated directly with BUMED without the CNO's being informed.

So the answer to question number one—Why an OP-093?—can be summarized as follows:

CNO needed a central organizational unit to coordinate policy, guidance and direction, and professional and technical advice on all health-care-related programs. In addition, this central office would be the focal

FIGURE 1



point for dealing with higher authority, for sponsorship of resources, and for appraising health care efforts Navy-wide.

The second question was, How is OP-093 structured?

VCNO memo of 11 April 1978 directed establishment of a new DMSO—OP-093—to be entitled the "Office of the Surgeon General." Figure 1 shows that organization. In addition to the Office of the Surgeon General, we have two major divisions—a Professional Division and a Planning/Programming Division—that will operate in the Pentagon.

This action made explicit that which has always been implicit: that the Surgeon General is the principal advisor to the CNO on medical program matters.

Specific functions assigned to OP-093 are to:

1. Develop Navy health care program policy and guidance and provide professional and technical advice on matters pertaining to naval health care.

2. Coordinate, as a sponsor for designated health

care programs, with other sponsors with regard to Navy/Marine Corps health requirements.

3. Review and appraise the capability of the Navy Medical Department to respond to contingencies.

4. Review and appraise the performance of the Navy Medical Department in safeguarding and protecting the health of authorized beneficiaries.

5. Act as central point of contact for naval health care matters involving coordination within OPNAV.

6. Act as central point of contact for health care matters concerning the Marine Corps.

7. Provide backup for meetings on health care matters.

8. Assist the DCNO for Manpower (OP-01) in the preparation of plans, policies, and studies pertaining to Navy medical manpower requirements.

9. Assist the DCNO for Logistics (OP-04) in the preparation of plans, policies, and studies pertaining to medical logistical support, including the prepositioned

War Reserve Material Program.

10. Assist OPNAV mission and resource sponsors in programs that have health care impact.

11. Advise and assist the CNO in exercising command responsibility over the Bureau of Medicine and Surgery.

12. Act as mission sponsor for medical.

13. Act as resource sponsor for medical and medical

training program elements.

Functions 12 and 13 assign to the Surgeon General those normal CNO staff programming functions of resource sponsorship and functional task sponsorship. Prior to establishment of OP-093, these functions were assigned to other OPNAV offices.

In his implementation memo of April 1978, the Vice Chief of Naval Operations assigned OP-093 a number of specific tasks. I will mention three, just to give you some notion of our charter and our charge.

First, the Surgeon General will program the medical resources and present the developed medical programs to the OPNAV decision-making bodies for the first time during the POM-81 cycle. Right now, the OP-093 staff is working with the BUMED and HSETC staffs on developing and presenting training programs for fiscal years 1981-1985.

Second, OP-093 is to emphasize, in Defense Health Council deliberations, medical readiness and contingency requirements for medical support, and is to institute procedures to keep the CNO and the VCNO aware of initiatives and developments.

Last, OP-093 will discourage new studies in health care, pending completion of review and action on past and current studies. (In a recent point paper, we identified 280 studies and reviews to the CNO.)

This brings us to our final question: What is the status of OP-093 today?

I am pleased to report that the life-sustaining equipment has been detached from the OP-093 patient. The organization is alive and on its own. Our military staff is assigned and in place, with equipment and telephones, at the Pentagon on the fourth floor, "B" Ring, Rooms 456-464. The OP-093 team has received enough tasks to last two years, and new tasks arrive daily.

Figures 2 and 3 show the organizational structure and the envisioned interfaces between OP-093 and BUMED.

The Surgeon General (OP-093) is located at Echelon 1, along with all other directors of major support offices and Deputy Chiefs of Naval Operations, while the Chief of BUMED sits at the Echelon 2 level, along with all other major claimants. The interface envisioned between OP-093 and BUMED is not unlike that which exists between OP-04 (the DCNO for Logistics) and the Naval Facilities Engineering Command. Primarily, the OPNAV organization operates in the upward arenas, while the Echelon 2 commands support the OPNAV organization and manage the field activities.

With medical teams at both of these echelons working together, and with resource and functional task sponsorships assigned to OP-093, the Surgeon General has a greater opportunity to gain visibility for Medical Department programs and problems, and to obtain resources to meet medical requirements in the future.

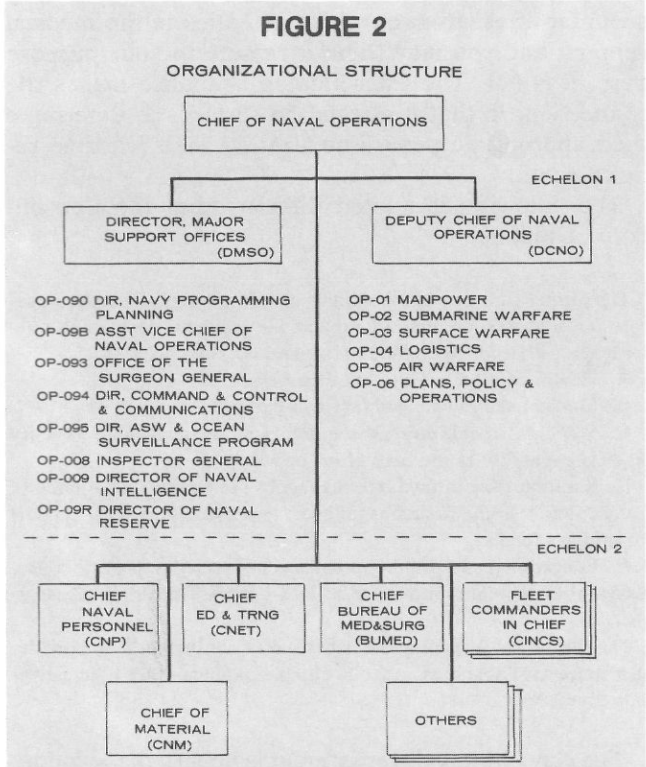


FIGURE 3: Interface Between BUMED and OP-093

OP-093 (SG)	Chief BUMED
Coordinate OPNAV efforts in health care field	Provide background data and analysis to OP-093
Develop health care policy	Translate and implement policies to BUMED command activities
Focal point for higher authority	Focal point for field activities' programs and problems
Resource sponsor for medical and medical training programs	Provide detailed resource data to support OP-093 resource efforts
Appraise health care efforts navywide	Evaluate performance and resource utilization of BUMED command activities

Contingency Planning

CAPT J.J. Quinn, MC, USN
Deputy Director of Program Planning and Analysis
BUMED Code 02-1

I intend to address three topics: first, what contingency planning is; second, why it is important; and, third, how contingency planning should affect the selection process for specialty training.

BUMED contingency plans are, simply, to use the resources of the Medical Department to meet the requirements of the operating forces. These requirements may range from a need for a single physician to a need for a surgical team to a need for the total resources of the Medical Department in support of an all-out war.

BUMED has initiated and maintains several programs to ensure its ability to meet these requirements. These programs include organizing surgical teams, training medical regulating teams, maintaining pools of physicians for duty with the fleet, and requesting funds for seven 1,000-bed fleet hospitals to provide support for a major war.

To grasp the importance of contingency planning to the Medical Department, it is first necessary to understand the Department of Defense planning procedure.

The first and most important point is that BUMED has neither the responsibility nor the right to create plans. In the great division of the world into "doers" and "providers," the Navy Medical Department falls with the providers. We make plans to support the plans the doers make. That is, they tell us what they need, and we make sure they get it. But who are "they"?

The cornerstone of the DOD planning process is a document called the "Consolidated Guidance," which is produced by the staff of the Secretary of Defense, on direction from the President. After Presidential review, it is published over the signature of the Secretary of Defense. It directs the services to plan to achieve specific missions, and provides guidelines which define those missions.

These guidelines are followed by the Joint Chiefs of Staff in formulating the Joint Strategic Capabilities Plan, or JSCAP. The JSCAP provides an assessment of the potential enemy threat in each area of the world and serves as guidance to the commanders in chief of various theaters in their formulation of operations plans, or OPLANS.

OPLANS are unconstrained. They specify the requirements which must be met in order for the CINC to defeat the enemy, and leave it up to the providers to assure that these requirements are met. It is here that BUMED and other resource and program sponsors enter the picture.

Each OPLAN has an associated medical annex as a part of its logistics section. The medical annex states the requirements for medical support of that particular OPLAN. BUMED's responsibility is to review that annex and to devise plans to support it. If, as is often the case, current Medical Department assets are not adequate to meet the requirements, we must develop programs to reduce or eliminate the shortfall. (The fleet hospital is one such program.)

The planning process is mission oriented. It may seem far afield from our daily activities in the medical centers, and you may think it remote to your purpose here. It is not. The Consolidated Guidance makes the connection, in that it directs the services to determine their appropriate peacetime sizes by their wartime requirements.

The following is quoted directly from the Consolidated Guidance:

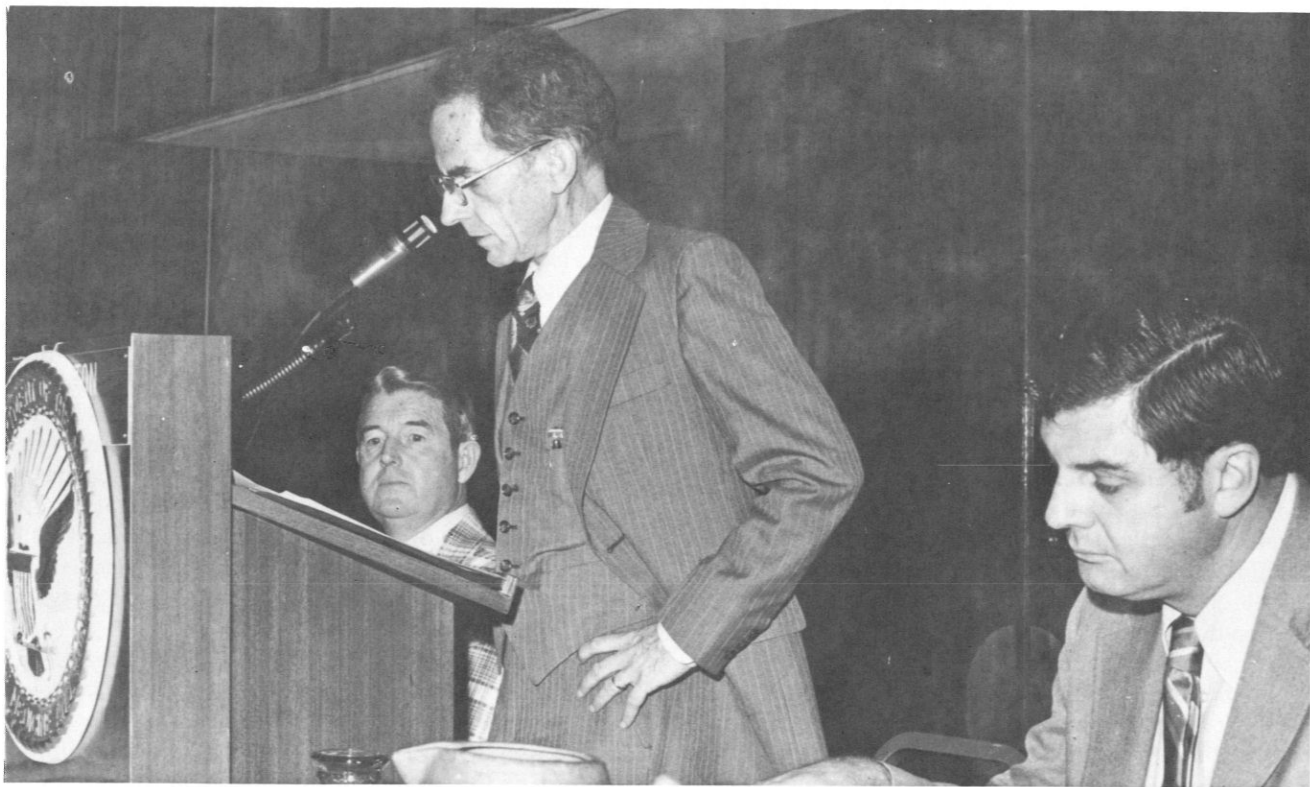
The primary mission of the military medical system is to plan, prepare for, and provide medical support for military operations in accordance with approved planning scenarios. This includes:

- A. Health care for active-duty members.
- B. Medical support for military contingencies.
- C. Sufficient mobilization base for rapid expansion of military medical capability in the case of major war.
- D. Rotation base to facilitate managing the substantial volume of transfer and training functions inherent in providing medical support for military forces.
- E. Educational and training programs necessary to provide a professional environment attractive to well-qualified health professionals.

The secondary mission of the military medical system is to provide, on a space-available basis, care to eligible patients other than active-duty members.

The Navy Medical Department is held to these guidelines in the planning, programming, and budgeting system. We must make an annual submission of our wartime requirements, calculated in accordance with the current Consolidated Guidance, and must show that these requirements justify our peacetime size. Our statements are subjected to intense scrutiny by Department of Defense analysts and Government Accounting Office and Office of Management and Budget staffs. Insofar as they detect logical flaws, inconsistencies, or ambiguities in the statements of requirements, they recommend decrements in our programs.

We face many problems in preparing to fulfill our mission, not the least of which is that the optimum specialty mix for the treatment of our peacetime population is different from the optimum mix for our predicted wartime patient load. This fact has not escaped the budget analysts, who persist in suggesting that the mismatch of peacetime specialties and wartime requirements demonstrates that we are unable to fulfill our primary mission with the physician assets we have.



SAC panel discussion: RADM R.G. Williams, Jr.; VADM W.P. Arentzen; RADM Stephen Barchet

They then argue that, since those assets would not meet wartime requirements, we should not maintain them in peacetime.

Our only defense is to show that physicians practicing in one specialty in peacetime can fulfill another function in wartime—that, for instance, a peacetime specialist in OB-GYN could do general surgery in a fleet hospital in wartime. Our training programs must assure that kind of cross-specialization if they are to survive the budgeting cycle.

The equivalent of the total personnel assets of the Medical Department might be required for in-theater support of a major war. The training programs we support must assure that our people are ready to deploy, and that they have the skills they will need to do so.

Given the intense scrutiny that every item in the DOD budget now receives from Congress, the Executive Branch outside DOD, and within DOD itself, there can be only one interpretation of our circumstances: Unless the Navy Medical Department can show that its services are available and ready to fulfill its primary mission, and unless it can show that its programs of training support that readiness, it cannot hope for support in the budgeting process. In short, our survival depends on our ability to convince the Chief of Naval Operations, the Commandant of the Marine Corps, and

their civilian superiors that we are able and ready to carry out our mission. The only arguments we can make that will carry any conviction are to respond promptly and fully to operational requirements, and to propose programs to relieve inadequacies in our ability to support those requirements.

It may lend a note of urgency to the problem for you to remember that the Secretary of the Navy testified before the President's Commission on Pay and Benefits to the effect that it was not necessary for the Navy to maintain a large peacetime Medical Department. We have, since then, prepared a briefing for him which succeeded in convincing him to alter his opinion. The fact remains, however, that we are viewed in many quarters as expensive, cumbersome, and dispensable in favor of civilian sector care.

All of which brings us to the question, How should contingency planning influence selections for specialty training?

Let me say first that we cannot compromise the quality of our health care system in any way. Those selected for advanced training in our system must be highly qualified academically, and of unimpeachable character.

But let me add that we cannot compromise our mission through failure to consider it in the selection

process. We must have training programs which prepare our students for their contingency, as well as their peacetime, roles. And we must have students in those programs who recognize that their responsibilities as naval officers stretch beyond the medical centers, and who are willing to fulfill those responsibilities when required to do so.

Today we have one surgical team and a two-physician augmentation unit at sea with the Marine Corps, in addition to the physicians, nurses, Medical Service Corps officers, and corpsmen normally assigned to those Marine Corps units. We have a medical care system, reaching from Yokosuka to Naples, which may be called upon tomorrow to support contingencies ranging from natural disasters to full-scale war.

The specialty training programs which cannot be identified with some aspect of contingency support, whether directly or through additional cross-specialty training, are in a most precarious situation. Likewise, the Medical Department cannot afford to train, or to retain on active duty, anyone who will not recognize his responsibilities and willingly fulfill them.

It is not enough, however, to select the right people for the job. Our training programs, as I have said, must be adequate to prepare our students to fulfill the contingency mission of the Medical Department as well as to serve our peacetime patients. Part of the task you assume here must be to define what additional training would be necessary to permit practitioners of each specialty to serve effectively in a combat theater.

The specialty mix required for treatment of combat theater casualties is, as you would expect, heavily surgical. The requirements for anesthesiologists and for surgeons in all specialties far exceed our peacetime assets. The questions you must address are these: What role would a specialist in my field play in field service with the Marine Corps? with the fleet? in a definitive-care facility in a combat theater? And, most important, how can the operational versatility of such a specialist be strengthened by emphasizing segments of specialty training, or by adding to it?

Let me close with a plea that you undertake the education of our younger physicians and of all members of the Medical Department team. As outstanding medical specialists, you enjoy the professional respect and admiration of all your colleagues and subordinates. They are, to a great extent, guided by your example. Insofar as you show them that the Medical Department must be committed to its primary mission, they will make it so.

Yet it is all too easy to become immersed in the job at hand and come to see the Navy as an adjunct to our hospitals, rather than vice versa. It is our responsibility to see to it that those we train remember those we are here to serve.

The peacetime posture and attitude of the Medical Department are made manifest to the operating forces through the people we assign to duty with them, and through the personnel of the surgical teams we deploy with them. As we all know, however, duty with the operating forces or deployment with surgical teams is frequently viewed with distaste by junior and senior members of the Medical Department and is either actively avoided or accepted with bad grace. We also know the reason for this: The duty is often boring. Few patients, if any, require more than routine treatment, and we are constantly aware that the work is piling up for us, awaiting our return. And duty with organic Marine assets can be uncomfortable as well as boring.

The point we must remember, and must drive home to those we train, is this: The operating forces are not conducting exercises for the fun of it. They are not, to use a phrase too often heard from physicians, wasting our time playing games. They are exercising so as to be ready to perform their mission, and they have a right to our support.

I need not harangue you on this subject, because you know these realities already. I must urge you, however, to bring those you train to share your realization. If they do not, they will alienate our natural allies in the line and Marine Corps and, in so doing, seal the fate of the Medical Department.

It has not been my intention to convey an overly alarming or melodramatic impression of where we are and what we must do; nor do I suggest any slackening of our efforts to provide superb medical care to our peacetime patients. Rather, I suggest that a full recognition of our potential wartime responsibilities is the best guarantee of our continued ability to provide the best of health care to all our patients.

Medical Readiness for Operational Contingencies

RADM H.A. Sparks, MC, USN
Deputy Surgeon General and
Assistant Chief for Headquarters Operation

At the outset of my remarks, may I offer one simple observation: that is, that each and every one here today has a very special involvement in the status and effectiveness of our Medical Department's operational medicine capability.

That is why we are here! It is our primary responsibility to conserve the military manpower of the Navy and Marine Corps. In peacetime we must maintain the health status of our forces through health education,

health protection, and personal health care, all of which has but one goal: readiness. Simultaneously, the Medical Department itself must be ready to make a prompt transition from its peacetime posture to a well-trained, properly outfitted, and carefully positioned worldwide Medical Department force.

We are an integral part of the naval warfare system of our nation. Our contribution to the nation's defense is to provide medical support to those naval forces whose mission is to control the sea lanes and to project power ashore.

Where did we come from? We were born of the line. Our birth as an organization came from recognition by the line that our skills were desirable and needed—and, indeed, medical personnel first appeared on board ship.

Today we have some 728,000 Navy and Marine Corps men and women in uniform. We have an additional 136,000 direct-hire civilians working in such facilities as naval shipyards, ordnance plants, and naval air and ship-rework facilities.

Our Surgeon General has set as our first priority the health care support of the operating forces. Our second priority is occupational and industrial health services to our civilian workers. Thus, we have medical responsibility for at least 860,000 people in our two top priority areas.

Another factor that must be considered is the strategic deployment of our naval and Marine forces over the entire surface of the globe. Although our logistic capabilities have increased, through the marvels of technology, so that we can move men, materials, medical facilities, and the like with relative ease, we often find ourselves engaged in new and hostile environments. The Medical Department of today's Navy must be prepared for contingencies in every area of the world, under any circumstance.

It is extremely important for us to understand the concept of a worldwide contingency health care system, for the resources to support it are being justified by carefully articulating such a concept, including the education requirement—which, of course, is why we are here today.

One hundred years ago, when the fleet began converting to steam boilers, great concern was expressed by fleet surgeons over problems created by stifling heat. Early changes in structural design, engineering changes, and limited watches for personnel were accomplished because of the concerned action of medical officers.

I can assure you that we still have those very same concerns today. And to that list of circumstances that impact on our operating forces, we can add such items as noise, asbestos, toxic paints and chemicals, ionizing and nonionizing radiation, lasers, and physical and



RADM Sparks

psychological stress caused by such things as G-factors or prolonged duty under the polar icecap, just to name a few.

Not only must we keep in touch with the latest developments in the medical/scientific community, but we must also keep abreast of the technological development of the Navy itself. We must be fully aware of both and be able to match both at any given point in time.

Perhaps the most awesome circumstance today is the technology of war itself, and the possible adversary we would face in such an event. There can be no doubt that the ultimate aim of communism remains the domination of the world and the elimination of the free-world democracies. There is also no doubt that the quickest, surest way of achieving this would be military victory over the West, if we were to relax our vigilance and strength. To this end, both sides have built up the greatest and most terrible array of military weapons known.

Since World War II, the Soviet Navy has been transformed from a basically coastal defense force into an open-ocean force, capable of carrying out general purpose naval missions supporting Soviet global political and military objectives. As of 1 July 1977, the Soviet fleet comprised approximately 2,875 ships. In numbers alone, that represents a fleet more than six times the size of ours.

There's no disagreement that a major war between the United States and the Soviet Union would be devastating to both sides and of relatively short duration. Quick-strike capabilities can bring the destruction of a nuclear attack to our land-based activities within a matter of hours. Fifty-five important U.S. cities, with

some 71 million people, are located within 530 miles of the 100-fathom-depth curves of both the Atlantic and the Pacific Oceans. Civilian and military casualties would run into the millions. Our major cities would be leveled, and our way of living, as we know it today, utterly destroyed. The responsive ability of the survivors would depend solely on offensive, retaliatory, mobile naval forces.

Let me compare the suddenness and short duration of such a war with what happened to us in World War II. After the attack on Pearl Harbor, we fought what amounted to a holding and delaying tactic until production and manpower reserves of the country were geared up to meet and defeat the enemy. At the same time, our medical people were learning as they went along.

Some say that combat medicine is not something that you can really get prepared for—that you only learn under combat conditions. Well, we'd better reject that notion, because I can tell you we won't have the time to learn as we go along.

In the Navy Medical Department, every uniformed man and woman must be ready within hours to take up his or her position in support of the operational forces of the Navy and Marine Corps. Each one of us had better know what we are doing under every conceivable circumstance.

The degree of readiness we attain during peacetime and our response time to varying levels of contingencies are the true measures of our competence as Navy medical officers.

What, then, should be the posture of the Medical Department today with regard to operational medicine?

The choice is not really ours; it has already been made for us by those in authority to make such choices. I've already told you of the priorities set by the Surgeon General. These priorities are established by the Chief of Naval Operations. Jointly, their objectives are to "give the highest priority to health care support of the operational forces" by providing "full preventive and curative medical and dental services to active-duty naval personnel."

The reality of our commitment to the operational mission can be found in the CNO's budget, which gives us our financial life's blood. Each and every billet in that budget is supported by its contingency requirement in support of the operational forces in case of mobilization. In plainer words, the only justification for any man or woman to be in the uniform of the Medical Department in peacetime is based totally on a projected wartime need.

In our considerations of how we make ourselves operationally ready, there are two areas that deserve our special attention.

First, all members of the Navy Medical Corps must recognize and appreciate their dual roles as military

medical specialists and as clinical specialists. We are not structured for personnel who see the Navy Medical Department as just another place to practice clinical medicine in the traditional sense. The acceptance of this dual responsibility cannot consist only of a tacit cerebral acknowledgment that, in case of war, "I will go forth and do my duty." Acceptance means we must be *ready* to assume those duties, and *readiness* requires us to be willing to devote a portion of our time on assignment with the operational forces either afloat or in the field. Any member of the Medical Corps who cannot accept the dual military-clinical role that sets him apart from his civilian counterpart has no business in the service. He or she should seek employment elsewhere.

Second, *all* medical education programs and work experiences must address themselves to the readiness preparation of Medical Corps personnel. The training education experience in peacetime must prepare us for all manner of circumstances, environments, and contingency situations.

By this I mean to emphasize that the training interface between clinical and operational medicine must be so close that no boundary can be discerned. To suggest that the two should not be mutually complementary is to deny reality. However, I must acknowledge that our current training programs are just not adequate to meet all fleet operational needs.

To remedy that deficiency, an operational medicine BUMED-HSETC training seminar-workshop was convened in San Diego on 12 June 1978, at the direction of the Surgeon General. The assigned tasks of that assemblage were to:

- Review and inventory present operational medicine practices in their relation to training programs and requirements.
- Identify specific knowledge and skill deficiencies, and recommend steps to overcome them.
- Recommend a general system of operational medicine training.
- Recommend career pathways of training and development in operational medicine.
- Construct initial curriculum outlines for selected operational training programs.

I am pleased to report to you that all of the above tasks assigned to the workshop were accomplished.

With respect to Medical Corps officers, the following recommendations were set forth:

- All medical officers entering active duty will attend 30 days (81 hours) of military indoctrination at Newport, R.I.
- Medical officers who have not done so will complete the GME-1 year.
- Medical officers may complete additional GME training in selected cases.

- Medical officers who may have completed all post-graduate training may be assigned to NRMCs or go directly to the Operational Medicine Common Core Training Course. Such schools are to be established in San Diego and Norfolk. The course curriculum will require 161 hours of study, and features occupational, industrial, and preventive medicine. All medical officers assigned to operating forces will attend and then proceed to additional operational training at the field, surface, flight, or undersea medicine training facilities, or to an operational tour in research facilities.

- Upon completion of the first operational tour, the medical officer may select additional professional training in residency, fellowship, or advanced degree programs. Some candidates may be selected for advanced special service schools.

I believe that the implementation of this task-oriented program will provide a cadre of 3,650 physicians who can serve with great satisfaction as qualified military-clinical specialists.

In summary, may I say that we must never lose sight of the job we have to do, and we must do that job with excellence.

Medical Department Personnel: Issues and Initiatives

RADM R.F. Milnes, MC, USN
Assistant Chief for Human Resources and
Professional Operations
BUMED Code 3

This is a time for me to consider your ideas, your concepts, and your plans—and a time for you to know what we are thinking and doing to provide you with the tools to give our patients the kind of medical care we know we can.

I have come to Code 3 with a positive spirit. I accept the concept that we are managing in an era of constant change, and that it is mandatory to accept this pace, which is fast, uneven, and certainly complex. It is also important to approach our tasks with the view that we can effect some positive results right now—and with the aim to do more in ensuing years. I can assure you that my staff and I believe we can.

Our assets are our people, our product, and our accomplishments. Our problems, simply stated, are accession, retention, and attrition. But manpower is people, not hardware. If hardware doesn't work, it breaks—and people react if things aren't right. Realizing this, I pledge my office to do what it can to

provide people with the opportunity to grow and attain a quality of professional life that they seek.

My goal is to provide full support for operational commitments and equally strong support for our training programs. The success of this dual support is vital for our future and our viability as a Medical Department.

I intend to create a sense of integrity in our interactions with you. It is necessary for all of us to communicate. Our effectiveness requires your help and involvement.

I view one general problem, in particular, with concern, and I solicit your support. I would ask all of you in positions of leadership to embrace wholeheartedly our efforts to demonstrate that operational tours are valuable—that such a tour is a positive challenge to anyone who has chosen to become a part of the Navy, and that this arena is one where much can be accomplished.

Our operationally deployed GME officers will do much to lend credence to our efforts and help solve this highly visible problem. However, we need to work together to turn this around to our advantage. This is crucial for our service integrity.

Next year, we will place 280 primary care medical officers in operational billets. That number is our commitment to the operation of the fleet and to the Marine Corps.

We do have some very positive aspects of our inventory. This year, 557 scholarship students have joined us, and not all of these students are entering at the first-year level. This certainly gives the coming years a much healthier look than we have been experiencing. These students are of high quality and come from well over 1,000 applicants—they really look good.

Family practice programs are delivering family practice specialists in increasing numbers. These physicians are in demand, and we are detailing them to more diverse locations, where they have been welcomed with open arms by our consumers.

The Physician's Assistant Program starts again in 1979, with an expected increased output of these valuable extenders, who will be able to help us not only in our clinics but also in certain operational areas that can utilize their expertise. We have already chosen a physician's assistant consultant, who will be stationed at the hospital in Charleston but will be responsive to all physician's assistants. He will provide an important interface with us at BUMED and lend a great deal of stability to the physician's assistant community.

The Nurse Corps has gained billets, and the people to go with them will increase the overall nursing community to help cope with the increasing demands made on nurses by new JCAH directives. These directives will require your attention, as they call for significant changes in nursing assessment and care plans. For

example, a patient classification system will be implemented in our hospitals, in order to determine patient needs for nursing care, and the long-range and daily nurse staffing requirements within the hospitals.

Physician recruiting has changed little from last year, numberwise. But quality has improved a great deal, and American-trained physicians are more numerous, even if on a small scale. We expect to recruit close to 200 medical officers this year.

Last year, 55% of those recruited were FMGs, and 45% were American trained. This year these percentages are reversed, and those FMGs who apply are more apt to have their citizenship. We like this trend, and you can affect it significantly by being responsive to your area recruiters.

The Variable Incentive Pay Program has been extended two years, and a new bill has come along to increase professional pay and eliminate some of the inequities and vexations of the present system. Also, there are strong indications that a pay initiative will be promoted for our enlisted personnel this next year.

The lack of ancillary help which all hospitals have experienced, and which is the source of adverse comments from our physicians, is getting attention. One hundred forty-four additional ceiling points have been added to our inventory in this problem area; however, recent events indicate that Congress once again intends to seek increased decrements in our civilian inventory. We have not solved this problem, but we are working on it.

Our major concern this year has been the loss of critical specialists. We are short in areas all too familiar to you: orthopedics, radiology, psychiatry, OB-GYN, and surgery. We don't have an immediate fix, but we do know there is something that will help, and that comes under the heading of personnel counseling. This needs your utmost attention, as it can limit attrition and increase retention. The devoted interest of a commanding officer, a director of clinical services, or a department chairman in the younger staff is, without question, where retention efforts are most effective.

When you can honestly project your positive spirit about Navy medicine, it is productive. I don't feel in any way that this request is passé, because it is one of the more commonly stated reasons physicians give when they leave the Navy.

Your efforts to retain our corpsmen are invariably worthwhile. Please take the time to talk with them and help them plan a future.

The decreased opportunity for promotion has been a negative factor in its effects on attrition and retention. This year, for Medical Corps officers, there will be a 90% opportunity to be selected as commander, instead of the 80% of last year. I am pleased that this has been turned around, and that we will be able to extend the

opportunity to attend executive medicine courses to selected lieutenant commanders in the Medical Corps.

The situation with regard to corpsmen is receiving a great deal of study and attention. For example, the Navy Occupational Task Analysis Program (NOTAP) is a study coming to fruition in the spring. This very detailed and extensive computerized evaluation of jobs filled by our corpspeople will let us upgrade occupational standards, help us learn about job satisfaction, and allow us to compare jobs for commonality or distinctiveness. It will help us utilize our corpsmen better, which unquestionably we need to do. We also can, with hard data, pursue our requirements more effectively with those who control the budget and distribution of our corpspeople.

We need new programs to assist our E-8 and E-9 community in gaining increased supervisory management skills. These are being developed and can significantly enhance the value of senior enlisted staff in all segments of the Medical Department. I strongly endorse greater involvement and utilization of the master chiefs and senior chiefs of our commands, and I urge you to do this also. They are in a position to unite a command and help you obtain the optimum from Hospital Corps assets.

In recent years, we have never been fully able to compete for manpower in Congress. Now we have the oncoming data from SHORSTAMPS, our Shore Requirements, Standards, and Manpower Planning System. The facts generated by this study give us a defensible manpower planning system which, when presented to Congress, will substantiate manpower needs and our budget requirements.

So far, only a small segment of medical activities has been analyzed. Orthopedics is one specialty whose study has been completed. It clearly demonstrated a requirement for more orthopedic surgeons than are presently authorized. We have, I believe, all known this to be true, but in the past we have not been able to quantify our needs to satisfy the statisticians.

The SHORSTAMPS methodology has been advantageous to other branches of the Navy and also to the Air Force. We believe it will help us also.

Finally, you need to know that we have factor-coded a number of our billets. Functional area coding was always a mystery to me, and I suspect also to you. Actually, these codes are used to identify billets that require special consideration or are not within stated policy.

In essence, functional area coding will help us alleviate our billet requirements. For example, 178 Medical Corps billets have been temporarily released to increase our numbers of nurse and Medical Service Corps specialists, such as dietitians, clinical psychologists, and nurse anesthetists.

We have FAC-coded 104 billets which support the operational units of the Marine Corps. These people are medical specialists who will remain at their assigned hospitals but will be required to have initial field medical training and yearly short periods of field updating. It is a viable solution to 100% manning of essential operational requirements. Our specialists will be able to work in their field of expertise, but will also be properly oriented to a role in contingency planning.

Medical Corps Manpower

CAPT J.E. Carr, MC, USN
Director, Medical Corps Division
BUMED Code 31

It has become a tradition in the Medical Corps Division that this SAC meeting marks the commencement of our detailing year. It's appropriate that we take this time to evaluate what we have accomplished, where we are today, and what our goals will be for the future.

As VADM Arentzen and RADM Milnes have mentioned, we are in a much better position now than we had anticipated at SAC IX, as the tables that accompany this presentation will confirm.

Table 1 is a historical comparison of our authorized billets and our onboard strength. It demonstrates that since 1969 our billets have decreased from 4,404 to the present level of 3,636. Our onboard strength has continued to fall, and we will be approximately 167 physicians below authorized billets on 1 Oct 1978. Last year, at SAC IX, we predicted that we would have a deficit between 250 and 450 physicians this year. We reached a shortage of 242 physicians in May 1978, and then our position improved. This was caused in part by an increase in extension on active duty requests and a leveling off in retirements and resignations.

Table 2 is a graphic demonstration of the authorized billets and onboard strengths as demonstrated in Table 1. It shows that our Medical Corps inventory has now reached a plateau, as predicted, and it is projected that we will continue to improve until we reach our Medical Corps requirements. My prediction now, at SAC X, is that our shortage of physicians should not be much worse in October 1979 than it is today, and hopefully will be somewhat better. As we enter the 1980s, we should be able to reach end-strength.

A comparison of the physician shortages in the three uniformed services is shown in Table 3. The Army is experiencing a deficit of approximately 1,500 medical officers, and the Air Force has a shortage double that of the Navy.

The Medical Corps grade distribution is presented in Table 4. The line Navy perceives that we are top-heavy in the grades of captain and commander, and it was this perception that influenced our promotion policies in recent years. Fortunately, Navy line leaders are understanding our position, and we are now seeing a reversal of our present restrictive promotion policies and, hopefully, a full return to a liberal promotion policy.

Table 5 shows the number and grade distribution of female medical officers on active duty. We now have 193 female physicians, representing about 5% of our strength. This level should steadily increase over the next decade, and this is causing a reexamination, in depth, of all the roles held by women in the military. We expect to assign our first female physicians to at least five ships, starting in July 1979.

We've been telling you for several years now that the Berry Plan is coming to an end. Table 6 shows that we accessed some 32 Berry Plan physicians this summer and will be looking for the last 9 during July 1979. The loss of this pool of specialists—which accessed some 750 physicians each year, and which provided us with approximately 1,500 on duty at any one time—will be sorely missed.

Table 7 is a display of the specialty shortages, comparing physician requirements with actual inventory. This is what you and your commanding officers tell BUMED that you need to carry out your mission. From this it is evident that we have a relative shortage in almost all specialties. But there is a problem with this.

TABLE 1: Medical Corps Worldwide

End Fiscal Year	Authorized Billets*	Onboard**
1969	4404	4482
1970	4231	4529
1971	3955	4253
1972	3858	4450
1973	4173	3954
1974	4143	3403
1975	3757	3391
1976	3656	3439
TQ	3696	3628
1977	3651	3524
1978	3636	3467
1979	3675	
1980	3611	
1981	3641	
1982	3643	

*Source: OPNAV 104

**Source: BUMED Code 31. Reflects end-strengths.

TABLE 2: Actual and Projected Medical Corps End-Strengths

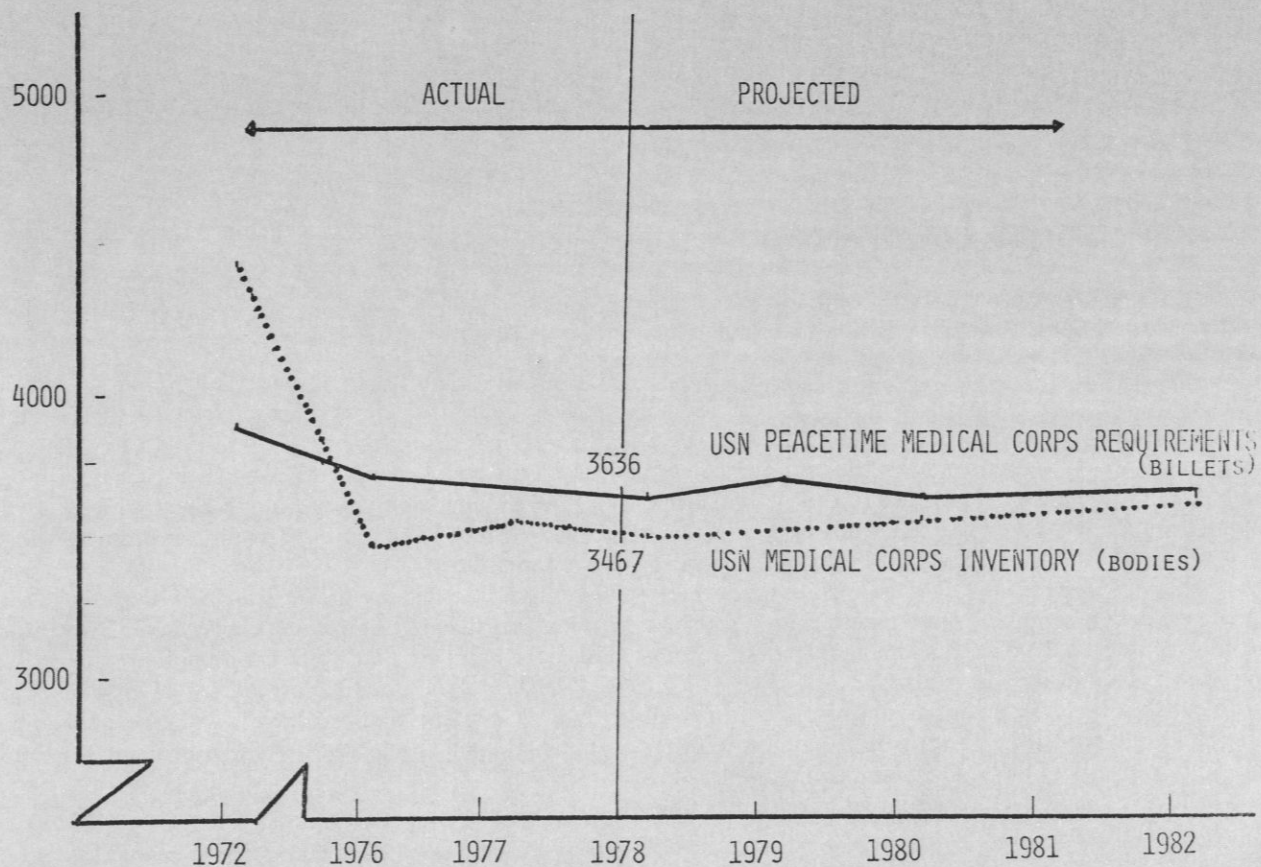


TABLE 3: Physician Shortage, 1 Oct 1978

Army	25.0%
Air Force	10.0%
Navy	4.6%

TABLE 4: Medical Corps Grade Distribution*

RANK	2100	2105	TOTAL
VADM	1	—	1
RADM	12	1	13
CAPT	362	24	386
CDR	371	72	443
LCDR	283	991	1274
LT	64	1286	1350
TOTAL	1093	2374	3467

*Data as of 1 Oct 1978
Source: BUMED Code 31

TABLE 5: Medical Corps Grade Distribution—Females

RANK	2100	2105	TOTAL
CAPT	2	—	2
CDR	6	2	8
LCDR	9	75	84
LT	1	98	99
TOTAL	18	175	193

TABLE 6: Berry Plan Accessions

YEAR	ACCESSIONS
July 70 (FY-71)	740
July 75 (FY-76)	418
July 76 (FY-77)	211
Oct 76 (FY-77)	136
Oct 77 (FY-78)	32
Oct 78 (FY-79)	9
Oct 79 (FY-80)	0

TABLE 7: Specialty Shortages (Requirement/Physicians) 1 Oct 1978

Specialty	Requirement	Inventory	+ / -	Percent
Flight Surgeon	300	193	- 107	36
Internist	292	267	- 25	9
Pediatrician	207	205	- 2	1
Family Practice	150	140	- 10	7
Dermatology	47	44	- 3	6
Psychiatry	143	99	- 44	31
Anesthesiology	101	95	- 6	6
Neurology	33	25	- 8	24
Physical Medicine	4	4	—	0
Radio Diag	121	69	- 52	43
Radio Therap	10	5	- 5	50
Nuclear Medicine	14	8	- 6	43
Pathology (Clinic)	89	88	- 1	1
Preventive Med (Gen)	12	4	- 8	67
Preventive Med (Aero)	42	30	- 12	29
Preventive Med (Occup)	16	12	- 4	25
General Surgery	152	125	- 27	18
Neurosurgery	17	16	- 1	6
OB-GYN	143	114	- 29	20
Ophthalmology	56	49	- 7	13
Orthopedic Surgery	124	86	- 38	31
Otolaryngology	61	52	- 9	15
Plastic Surgery	19	19	—	0
Thor & CDV Surgery	39	36	- 3	8
Urologist	43	40	- 3	7

TABLE 8: Selected Medical Officer Inventories, 1 Oct 1978

Specialty	RESTRA	BC	FT	Inventory*	Specialty Requirements**
Anesthesiology	43	22	75	97	88
Dermatology	22	29	17	46	41
Emergency Medicine	2	—	2	2	1
Family Practice	73	50	103	153	117
Internal Medicine	110	76	213	289	227
Neurology	11	5	16	21	25***
Nuclear Medicine	4	2	3	5	7***
OB-GYN	59	35	95	130	114
Ophthalmology	27	23	36	59	51
Otolaryngology	30	24	31	55	56***
Pathology	43	50	31	81	69
Pediatrics	45	79	129	208	165
Preventive Medicine	5	19	9	28	27
Psychiatry	30	24	79	103	100
Radiology	47	57	24	81	94***
Surgery—General	52	46	86	132	124
Surgery—Neuro	11	5	15	20	11
Surgery—Orthopedics	46	23	70	93	80
Surgery—Plastic	3	4	10	14	7
Surgery—Thoracic/CDV	4	10	18	28	13
Urology	25	14	26	40	36

*Inventory does not reflect specialties assigned to executive medicine (99) or medical research (47), and total does not include medical officers in residency training.

**Requirements defined by authorized specialty billets.

***Shortages defined by billet authorizations.

TABLE 9: Desired Primary Care Specialists

Family Practice	280	
Internal Medicine	220	
OB-GYN	160	
Pediatrics	190	
Clinical specialty subtotal		850
Aerospace Medicine	300	
Submarine Medicine	78	
Military specialty subtotal		378
Nonspecialists		504
Total		1,732

TABLE 10: Primary Care Specialists Actual Inventory

	FY-77	FY-78	Difference
Family Practice	94	128	+ 34
Internal Medicine	185	156	— 29
OB-GYN	141	124	— 17
Pediatrics	191	211	+ 20
Clinical specialty subtotals	<u>611</u>	<u>619</u>	<u>+ 8</u>
Aerospace Medicine	220	184	— 36
Submarine Medicine	48	40	— 8
Military medicine subtotals	268	224	— 44
PCMOs	411	475	+ 64
Subtotals	<u>679</u>	<u>699</u>	<u>+ 20</u>
Totals	1290	1318	+ 28

TABLE 11: Physician Recruitment*

Year	Goal	Appointed			Total Applicants	Appointment/ Applicant Ratio
		LT-LCDR	CDR-CAPT	Total		
FY-75	394	128	31	159	456	2.87
FY-76	187	157	30	187	512	2.74
FY-TQ	240	106	0	106	392	3.69
FY-77	493	175	1	176	618	3.51
FY-78	495	152	7	159	476	3.00

*As of 6 Sept 1978

**TABLE 12: Specialties of Physicians Recruited
FY-77**

	U.S. Graduates	Foreign Medical Graduates
General Surgery	5	5
Psychiatry	4	7
Neurosurgery	3	0
GMO	17	33
Pediatrics	8	13
Aviation Medicine	12	3
Dermatology	2	0
Anesthesia	4	4
Internal Medicine	7	10
Submarine Medicine	1	0
Pathology	3	6
OB-GYN	3	10
Family Practice	4	1
Orthopedics	1	1
Ophthalmology	2	0
Radiology	1	5
Urology	0	1
Totals	77	99 = 176

**TABLE 13: Specialties of Physicians Recruited
FY-78***

	U.S. Graduates	Foreign Medical Graduates
General Surgery	7	3
Psychiatry	8	8
Neurosurgery	2	2
GMO	14	18
Pediatrics	11	11
Aviation Medicine	13	2
Dermatology	0	0
Anesthesia	2	3
Physical Medicine	1	0
Internal Medicine	12	8
Submarine Medicine	1	0
Pathology	2	5
OB-GYN	3	5
Hematology	1	0
Family Practice	3	3
Orthopedics	2	0
Radiology	2	3
Ophthalmology	1	1
Urology	1	1
Totals	86	73 = 159

*As of 6 Sept 1978

Table 8 compares our physician inventory, not with need or requirement, but with *authorized billets*. In this display, our shortage is not so apparent, and it would appear that we have a deficit in only several specialties. This is our daily problem: to document what our requirement actually is. Stated simply, we do not have enough billets to take care of our entire beneficiary population.

Table 9 is a presentation of our *desired* primary care requirements. We would like to attain a goal of 47% of the Medical Corps in those primary care specialties. Family practice should double over the next 5-10 years.

Table 10 is a display of our *actual* inventory of primary care specialists. They are now at 38% of the Medical Corps, an increase from 35.6% last year.

Physician recruitment over the last four years is dis-

TABLE 14: Armed Forces Health Professions Scholarship Program

Fiscal Year Degree Received	Number of Graduates	Navy Interns	Navy Residents	Civilian Interns	NADDS Deferment
1975	300	92	45	30	133
1976	356	80	52	214	10
1977	250	172	0	49	29
1978	295	185	0	63	47
1979	400	200/250	0	100/150	0/50
1980	400	200/250	0	100/150	0/50
1981	400	200/250	0	100/150	0/50

**TABLE 15: PCMOs (GMOs) Needed for
Operational Billets (Summer 1979)**

Fleet, Atlantic	52
Fleet, Pacific	52
Marines, Seabees, Regions	106
Flight Surgeons	50
Sub Med	20
	<u>280</u>

**TABLE 16: PCMO Assets to Fill Operational
Billets (Summer 1979)**

Navy Interns	(July 79)	220	(23 female)
	(Jan-Mar 79)	16	
	(Sept 79)	<u>2</u>	
		238	
Civilian Interns	(July 79)	60	(3 female)
	(Jan 79)	<u>5</u>	
		65	
Total			303

played in Table 11. Recruiting for FY-78 will be about the same as for FY-77, and we now are able to access some commanders in certain critical specialties.

Table 12 is a final report for recruiting last year (FY-77) and shows that foreign medical graduates exceeded U.S.-trained graduates during that year. This trend has now been reversed, as you will note in Table 13.

The Armed Forces Health Professions Scholarship Program is displayed in Table 14. We were able to select some 557 students from more than 1,000 applicants, and our program is fully subscribed. This will increase the number of graduates available to us. We have increased the number of Navy internships and hope to increase civilian deferments in the future. This expanding pool of scholarship students—which, together with graduates of the Uniformed Services University of the Health Sciences, will provide us with approximately 1,500 physicians on active duty at any one time—is our hope for the future. We will need to train them in order to provide our specialists of the future.

For four years now, we have promised the line Navy that we would support the fleet with 100% physician manning. We have done a pretty good job, and we intend to carry out that promise again next summer. Table 15 shows that we will need 280 primary care medical officers to replace those vacating operational billets next summer. Table 16 shows where our assets are to come from to fill those operational billets, and you can see that the margin is very narrow.

Please forgive me if I appear to be overly optimistic. But we have been through, and are going through, a very difficult time, and yet the signs are improving. The quantity and quality of scholarship students is markedly increased. Extensions are ahead of last year's numbers. Recruiting is holding its own, and the quality of recruits is decidedly better.

Again it has been confirmed that we cannot depend upon recruitment to supply us with trained specialists. We must continue to try to train at full capacity, while supporting the operational Navy to the best of our ability.

Budget Update: Dollars, Facilities, Equipment

RADM A.C. Wilson, MC, USN
Assistant Chief for Materiel Resources
BUMED Code 4

This morning I want to address the current status and outlook on the Medical Department's money, places, and things. Since money is critical to virtually everything, I will start with the status of funding, then describe for you the facilities and equipment milieu.

In retrospect, we have not fared too badly in FY-78, although we've had some anxious moments at various times, wondering whether or not this or that piece of the budget would be approved or withheld.

The Navy Medical Department is a microcosm of the government as a whole, in the sense that it responds to the various pressures brought on by changes in this country and the world in general. The circumstances which are now influencing our budgetary matters are several—for example, the Presidential pledge of a balanced budget, which means either higher taxes or lower government costs. Proposition 13 in California has had an enormous impact and has been the driving force in reduction of government spending.

In the Medical Department we have experienced a consistent decline in workload, due in part to reduction of the end-strength of the Navy and Marine Corps and in part to reduction in the average length of patient stay in the hospital. Yet, when the length of patient stay is reduced, the cost per patient day rises, because the cost of keeping the door open either remains stable or rises.

In 1976, there was a \$10 million reduction in BUMED's budget base. Since the budget is constructed on an incremental basis—i.e., next year's budget is usually this year's budget plus some new programs plus inflation—the base on which the next budget is calculated is critical. To date we have been unable to get the budget base restored to the figure that it would have been prior to 1976, using a 1975 base. That's been a problem.

As a part of the Navy, we have received our fair share of general forms of reduction. Over the past few years, these have included dollar reductions; staffing reductions, both in uniformed personnel and civil servants; constraints on travel funds; reduction in dollars to deal with inflation; and limitations on the growth of some desirable programs, such as OSHA.

As you are well aware, the history of low funding has created some retention problems. We are, by law and custom, expected to deliver health care on request. Any reduction in care, whether real or imaginary, is perceived as a condition which is reversible if one complains loudly enough.

FIGURE 1: Major Budget Changes for FY 1979 (as Requested in FY 1979 President's Budget)		
		(\$000)
General Support Staffing (270 civilians)	+	1,646
Occupational Health (80 technicians)	+	2,000
Safety (14 safety officers)	+	119
Hearing Conservation (16 technicians)	+	144
Maintenance and Repair—Real Property	+	6,202
Minor Construction/Alteration	+	1,048
Laboratory Technicians (38 civilians)	+	276
Inflation	+	12,248
Total—Major increases	+	23,683

FIGURE 2: FY 1980 Budget (Currently Undergoing Navy/OSD/OMB Review)		
		(\$000)
Major Changes:		
Occupational Health (Contracts)	+	2,645
Maintenance and Repair—Real Property	+	7,000
Closure of Inpatient Functions at Several Hospitals	—	2,451
Inflation	+	12,894
Net Change	+	20,088

ceived as a condition which is reversible if one complains loudly enough.

There is another issue impacting on us, and that is doing as much as possible by contract.

If we contract for a service, it obviously means that we do not require a Civil Service employee or a uniformed individual to do the job. This impacts on the Civil Service end-strength of the Medical Department, and can impact on our uniformed strength as well.

Certain functions in selected activities lend themselves to contracting out—for example, housekeeping and food services. But those skills which we are required to take with us when we go to war—the skills of men and women in uniform—must continue to be exercised. Our efforts are devoted to determining where and what we should contract out, and what skills we must protect as the necessary ones for contingencies.

The bottom line for all these issues is that we are being asked to do more with less. We try to cut corners to save dollars, but there are pressures beyond our control which do not permit our independence in these



RADM Wilson



CAPT Carr

matters. As a result, we find ourselves in a "reaction" posture rather than in an "action" posture. We are sometimes asked to refight battles we thought we'd already won.

Figure 1 shows the major budget changes in FY-79. There's a strong emphasis on occupational health, maintenance, minor construction, and addressing the inflation problem.

We're getting dollars for FY-79, but as of today we do not have a firm control number that tells us what our dollar figure will be. We do know that we have had our inflation line item decreased by about one third, but the other decisions haven't been announced. The general feeling about FY-79 is that it may not be a vintage year, but it may not be all that bad, either.

Figure 2 outlines the major changes we've asked for in the 1980 budget, which is currently undergoing review by Navy, OSD, and OMB.

In the upcoming year, the Medical Department needs the conscious efforts of all its members to assure that we spend our money wisely and well and get the maximum benefit from it. These are some of the things you can do to contribute to sound financial management:

- Get involved and stay involved. As program managers, you know there's nothing in this country that changes as rapidly as the price of things. To manage your money adequately, you must know not only what you have and what it costs to operate and maintain, but also what you want to replace and what it costs to buy the replacement.

- Being a target manager or a program manager does not mean only spending money. There's a requirement to *manage* those dollars: to identify alternatives and options, and to spend those dollars on the best options. If you've had no experience or are having trouble managing your department's budget, the fiscal or supply officer would be happy to give you a hand and help you learn.

- You must stay current, for the reasons we've just mentioned. The marketplace changes daily, and what you determined was a sound operating cost or replacement cost last week is likely to be out of date this week.

- You must learn to forecast—to look ahead and identify problems before they occur—so we can plan for that new piece of equipment you need to stay abreast of the state-of-the-art of medicine. Problems and requirements need to be identified early.

- Finally, you must plan ahead. As you know, the Navy and the government at large operate on a five-year defense plan. We need similar plans for the Medical Department and its activities, and this includes your department. You need to think about and discuss what things are probably going to transpire in the next five to ten years. Will the anticipated changes in the state-of-the-art affect your specialty? Will those changes require more people, more money, more space, or additional equipment? If they do, how much, and what kind of each will be required?

In 1974, we started a medical modernization program for our facilities, designed to remedy construction needs over a five-year period. The money for this pro-

gram was held under tight control by DOD, through a mechanism known as "fencing," for the first three program years. In FY-77, however, the money was unfenced, and control was returned to the individual military services.

We've accomplished an enormous amount of construction since 1974: 68 major projects were authorized, and 13 are still under way. In FY-79, we have six projects: a new hospital at Camp Lejeune, a new regional dental center at Norfolk, the third phase of center redevelopment at Bethesda, replacement of the biomedical research laboratory in Cairo, an industrial clinic at MCAS Cherry Point, and a medical/dental clinic for the basic school at Quantico.

We still have \$900 million worth of construction to accomplish; however, in FY-78 the Medical Department construction program was all but eradicated. We built one BEQ in FY-78.

FY-79 looks better, with a pricetag of about \$71 million on those projects I mentioned.

One point should be remembered: All the work in the Navy Medical Department is important work or we wouldn't be doing it. But every program we present is in competition with ships, aircraft, weapons systems, and other Navy programs. There's a strong feeling in government today that we must do everything possible to maintain what we have, at the same time competing appropriately for new things. In the facilities world, this means more emphasis on maintenance and repair of existing systems and spaces, and it means that you must be continually aware of the maintenance needs in your own areas of responsibility.

Just for a moment, I'd like to highlight some of the things that are now going on.

We returned some property to the Japanese government, on a *quid pro quo* basis, and they're building a new hospital for us in Yokosuka that should be ready for us to use in about a year.

The new hospital at Bethesda is about 18 months from completion, and construction is going along very nicely. The last phase of the total NNMC project—modernizing the tower and other older buildings—is programmed in FY-81.

As many of you know, we've had considerable difficulty siting the San Diego replacement hospital, but we hope the issue of the new location will be resolved shortly, so we can get the new hospital built.

We're starting a tri-service study of medical care needs in the Oakland Bay area, the driving force behind which is the fact that, as new as Letterman and Oak Knoll are, they've not designed to withstand earthquakes. Both of them need seismic upgrading, which is very expensive, and that's the reason for this study: to determine if we need both hospitals and, if not, which one should close? We're well aware of the large con-

tribution Oak Knoll makes to our total training effort. Suffice it to say that no decisions have been made ahead of time, no commitments have been made, and the study will be objective.

As you know, the New Orleans hospital is finally closed. We don't know what's going to happen to it, but it's being offered for lease.

The final issue I'd like to discuss is our equipment program.

The Equipment and Logistics Division, BUMED Code 43, was established a year ago, with CAPT Lou Mantel as its director. We now have a much better management system for our equipment than we had before. We've had good support from CNO in FY-78 in getting equipment dollars. FY-79 doesn't look quite as favorable, but we're still far better off than in many years in the past.

You're undoubtedly well aware that the computer tomography scanner has brought a new kind of surveillance to the equipment program. Virtually every governing body in the country, from OSD down to the local community health planners, is interested in controlling the number of CT scanners. We're doing reasonably well in our own program.

We're planning new equipment-related programs for the upcoming year, the most important of which is better preventive maintenance. LT Tom Defibaugh has been transferred to BUMED Code 43 from Philadelphia's Naval Medical Materiel Support Command, and he'll be setting up the maintenance program.

We also anticipate moving the Naval Medical Materiel Support Command to Fort Detrick. The Army and Air Force have their medical materiel divisions there, and the move will allow us to take advantage of the other services' systems and programs.

BUMED Code 42 will continue its usual function of caring for the fleet, but in addition will start some new activities, including an inventory control system for investment equipment and some noninvestment equipment. To sum up, we've talked about money and how hard it is to come by. We have to use it wisely. We've had pretty good luck this year, and we're hopeful about next year.

We've said that the military construction program is constrained in funding somewhat, but we're still building some new facilities, and we're making some progress.

The equipment scene is improving. We're modernizing and enlarging the equipment acquisitions system in BUMED, and putting emphasis on proper selection, proper utilization, and proper maintenance.

All these issues involve you as program directors, and it is incumbent on you to contribute your time and expertise when indicated, so that we can continue to march along in the right direction.

Your Reimbursements: Speeding the Process

If you are a student in the Armed Forces Health Professions Scholarship program (AFHPSP), you are familiar with reimbursement claims. They are a necessary evil, requiring time to fill out and time to process. They are completed on Standard Form 1164 and are submitted once each fiscal quarter.

Reimbursement claims take approximately four to six weeks to process and are responsible for about 40% of the workload at Code 9, Health Sciences Education and Training Command (HSETC). This is the process that your reimbursement claim (along with 1,500 others each quarter) must undergo before payment can be made:

- About a month before the end of each federal fiscal quarter, a blank SF 1164, an instruction sheet, a school certification, and an information letter are mass-mailed to all AFHPSP students.

- You and other students in the AFHPSP complete your claims for the applicable fiscal quarter (termed "purchase period" on the instruction sheet) and return them to Code 9, HSETC.

- When we receive your claim, it is date-stamped, then screened for signature, purchase dates, mixed purchase periods, social security number, and readable carbon copies. Claims are immediately returned when there are discrepancies in any of these areas.

- After your claim is screened, the receipts are copied and passed on to your processor. The processor reviews your past claims, checks your items against your receipts, checks the addition, separates the

amounts into categories (books, supplies, fees, microscope rental), and enters the categorized amounts on your personal record and in a master financial book that maintains a running total of all money expended on behalf of Navy AFHPSP students. The processor must then type accounting data and signature information on your claim. The first carbon copy and a copy of all your receipts are filed in your personal financial record while the original claim, with remaining copies and receipts, is forwarded to the HSETC comptroller for further review and signature.

- The HSETC comptroller's office screens your claim for accounting-data accuracy and sends one carbon copy to the fiscal office at the National Naval Medical Center for keypunching. This is the copy that charges the amount of your claim against HSETC funds. The original claim and the remaining copies are then forwarded to the Navy Regional Finance Center (NRFC) in Washington, D.C.

- NRFC processors review the claim, check your receipts, check the addition, and finally forward your claim to their fiscal office for payment. The fiscal office makes out your check and forwards it to you, using one of your claim copies in a window envelope. The original claim and remaining carbon copies are used for other purposes within NRFC.

As you can see, your claim passes through many hands. There can be a bottleneck at any point along its journey when processors take leave, report sick, spend too much time on

"problem" claims, or attend to other more pressing matters that divert them from their processing duties.

Your help counts. You can help speed the flow by submitting neat, legible claims and closely following the instructions that accompany each claim form. Unfortunately, many students do not read the instructions and are perturbed when their claims are returned for seemingly minor discrepancies. For a time, these minor discrepancies were simply corrected by the processors. As time passed, however, more and more students were disregarding the instructions, to the point where almost every claim needed some type of correction or adjustment. It became apparent that the only way to ensure that claims were properly completed was to return them to the student whenever there was a discrepancy.

One of the most frustrating problems encountered by NRFC is carbon copies that cannot be read. Every copy is used, and *all must be legible*.

We do not like to return your claim because of minor errors, but it is the only way to ensure proper submission in the future. Claims processing is not a simple, one-office procedure. Each office in the processing chain must abide by established laws and regulations. That is why we are so particular about receipts, dates, signatures, legibility, content, and neatness.

We may not be able to change the system, but with your help we may be able to make it a little more responsive.

SURVEY TO DEVELOP PHYSICIAN WORK PROFILE

... In the latter part of this month and early in December, the Naval School of Health Sciences, Bethesda, Md., will be conducting a survey of all shore-based Navy physicians.

Past surveys, which have tended to focus on career satisfiers and dissatisfiers, have too often resulted in conclusions and recommendations that are not readily subject to in-house control. The current survey, however, addresses the Navy physician's immediate job environment. What does the physician do? Who supports him or her? How well is he or she supported? What organizational factors enhance or inhibit the physician's work?

With an accurate physician work profile, Medical Department managers can better modify organizational arrangements so as to match physicians' professional goals with the varied needs of their patients.

Since a survey investigation, by its very nature, requires the whole-hearted cooperation of respondents to be successful, the Research Department of the Naval School of Health Sciences earnestly solicits that cooperation from Navy physicians in the days ahead.

MED SCHOOL OPPORTUNITIES IMPROVED . . .

ROTC and service academy graduates can now participate in government medical education programs. The three military services have moved to allow ROTC graduates and as much as 2% of the graduating class of each academy (depending upon service needs) to enter the Armed Forces Health Professions Scholarship Program or attend the Uniformed Services University School of Medicine.

FLIGHT SURGEON BILLETS AVAILABLE . . . Billets are available for flight surgeons at the Naval Aerospace Medical Research Laboratory, Pensacola, Fla., and the Naval Air Development Center (NADC), Warminster, Pa.

The NADC billet is described as follows: "A new generation of Navy aircraft is capable of sustained high-G flight. At NADC, research is directed toward enhancing pilot performance for the demands of this environment. There is an immediate requirement for an experienced flight surgeon to become a member of a multidisciplinary research team employing the most sophisticated human centrifuge in the free world and other acceleration platforms. Other research activities encompass cold water survival and perceptual studies. The incumbent also supervises a Navy subject pool, reviews and coordinates research efforts involving the

use of human beings, provides interagency liaison for programs using Navy acceleration platforms, and provides medical care for NADC's aviation community. In-house research funds are available for approved independent research."

Blue Angels. The Navy Flight Demonstration Team will require a flight surgeon in January 1979. LT Bernard Gipson, MC, USN, currently with the "Blues," can provide detailed information.

Anyone interested in any of these challenging billets should call CDR Jim Black, MC, USN, BUMED Code 311-1, at Autovon 294-4390.

POSTDOCTORAL ASSOCIATESHIPS . . . Applications are now being accepted for the postdoctoral research associateship programs conducted by the National Research Council of the National Academy of Sciences on behalf of the Naval Medical Research and Development Command (NMRDC).

Under the programs, postdoctoral biomedical engineers and medical, biological, and behavioral scientists participate in biomedical research projects conducted in NMRDC laboratories. Awards, made on a competitive basis, are tenable at five Navy facilities: the Naval Medical Research Institute, Bethesda, Md.; the Naval Aerospace Medical Research Laboratory, Pensacola, Fla.; the Aircraft and Crew Systems Technology Directorate, Naval Air Development Command, Warminster, Pa.; the Naval Submarine Medical Research Laboratory, Groton, Conn.; and the Naval Health Research Center, San Diego, Calif.

Areas in which the research associateships are awarded are: experimental medicine, immunology, undersea medicine, aerospace medicine, behavioral sciences, biochemistry, biophysics, environmental stress, microbiology, parasitology, virology, biomagnetics, physiology, and radiation biology.

Candidates must hold an M.D., a D.D.S., or a Ph.D. degree or the equivalent, and must be research oriented.

The National Research Council screens the candidates' records, selects applicants, and approves the scientific merits of laboratory projects and the credentials of research advisors.

Applications must be postmarked no later than 15 Jan 1979 and must be received in the Council's Associateship Office no later than 25 Jan 1979. Supporting documents must be received by 12 Feb 1979.

For further details, write: Associateship Office (JH-608-NI), National Research Council, 2101 Constitution Ave., N.W., Washington, D.C. 20418.

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